



RESERVE HEALTH READINESS PROGRAM HISTORICAL UPDATE REQUEST FORM

SERVICE MEMBER INFORMATION: *Must be completed by Service member or military authority*

LAST NAME, FIRST NAME, MI:	DATE OF BIRTH:	FULL SSN:	PHONE NUMBER:
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- ☐ Check box if Service member has separated from Service
(Records for separated Service members will be scanned into HRR. Medpros will NOT be updated)

REQUESTED UPDATE: *Select the services you would like to update (Check all that apply)*

Documentation required to update the following:

- | | | |
|---|-------------------------------------|--|
| <input type="checkbox"/> IMMUNIZATIONS | <input type="checkbox"/> G6PD | <input type="checkbox"/> SICKLE CELL |
| <input type="checkbox"/> VISION SCREENING | <input type="checkbox"/> BLOOD TYPE | <input type="checkbox"/> PREGNANCY - ESTIMATED DUE DATE: |

- ☐ **IMMUNIZATION EXCEPTIONS** - Documentation required with provider signature

Exception #1 Immunization type:

Expiration date:

- ☐ Medical temporary ☐ Medical permanent ☐ Immune ☐ Assumed

- ☐ **MEDICATIONS**

Does the Service member have a 180 day supply of prescribed medication(s)?

- ☐ Yes ☐ No ☐ N/A, the Service member does not require prescription medication(s)

- ☐ **MEDICAL WARNING TAGS**

Does the Service member have required medical warning tags in his/her possession?

- ☐ Yes ☐ No ☐ N/A, the Service member does not require medical warning tags

- ☐ **HEARING AID BATTERIES**

Does the Service member have hearing aid batteries in his/her possession?

- ☐ Yes ☐ No ☐ N/A, the Service member does not require a hearing aid

REQUESTOR INFORMATION

NAME (PLEASE PRINT):	TITLE:	
EMAIL (CONFIRMATION EMAIL WILL BE SENT):	PHONE NUMBER:	RELATIONSHIP TO SERVICE MEMBER:
SIGNATURE:		DATE:

MEDICAL SUBMIT TO: HistoricalUpdates@logisticshealth.com

Fax: (888) 888-8476 **Phone:** (800) 666-2833, extension 3586

DENTAL SUBMIT DD2813 TO: HistoricalUpdates-Dental@logisticshealth.com

Fax: (608) 793-2960 **Phone:** (800) 666-2833, extension 2030

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